# Care Management
# PCMH Committee

## Person-Centered Medical Home

January 13, 2016

Connecticut Person-Centered Medical Home

HUSKY HEALTH CONNECTICUT

# PCMH Program Status Update

***101 PCMH Program Participants**
372 Sites
1,353 Providers

**69 PCMH Approved Practices**

Recognized at NCQA Level 2 or Level 3

**21 Glide Path Practices**

Working towards NCQA recognition

**1 Glide Path Renewal Practice**

Working towards NCQA renewal recognition

**14 PCMH Accredited Practices**

Includes FQHCs

**Please Note: 3 Practices have sites in both PCMH & Glide Path Programs**
**1 Practice has sites in both Glide Path & Glide Path Renewal Programs**

**This data reflects current information as of 12/31/2015**

# Glide Path Renewal Option

- DSS PCMH Program requires practices to maintain their NCQA PCMH Recognition.
- NCQA 2014 Standards policy recommends that practices submit their renewal recognition to NCQA ***two months prior to their expiration date.***
- Practices that do not receive their renewal recognition prior to their expiration date are at risk for:
  - Decrease in enhanced rates to 14% or even 0%
  - Losing their qualification for performance and improvement payments, which are provided to PCMH practices annually based on practice outcomes for PCMH Health Quality measures

# Glide Path Renewal Option

- Practices that submit their PCMH renewal to NCQA by their expiration date will be given a 3 month grace period after the expiration date (with no enhanced rate changes) to receive renewal email from NCQA.
- Practices that are not able to submit their PCMH renewal to NCQA by their expiration date, will be able to remain in the DSS PCMH program with enhanced payments adjusted to 14%.
  - Rate will remain effective until the practice receives their NCQA PCMH Level 2 or 3 Recognition.
  - Submission to NCQA must be done within 6 to 9 months of the expiration date.

# Glide Path Renewal Option

Glide Path Renewal Option Requirements:

- The practice ***must submit a Glide Path Renewal Application for each site within 30 days of the NCQA expiration date.***
- The practice will be required to complete the PCMH Recognition Checklist in collaboration with their Community Practice Transformation Specialist (CPTS) within 30 days of the Glide Path Renewal Application submission
- The practice will be required to complete a revised PCMH Recognition Checklist every three months in order to monitor their progress.

# PCMH Program Status Update

## 69 PCMH Approved Practices

70 last reported – December 9, 2015
1 Practice completed Glide Path
1 Practice voluntarily termed
1 Practice transitioned to Glide Path Renewal status

## 233 PCMH Approved Sites

241 last reported
1 added
4 termed
5 went to Glide Path Renewal status

## 834 PCMH Approved Providers

854 last reported
24 added
2 termed
42 went to Glide Path Renewal status

# PCMH Program Status Update

## 21 Glide Path Practices

21 last reported – December 9, 2015
1 new Glide Path Practice
1 Practice Completed Glide Path

## 1 Glide Path Renewal Practice

### 31 Glide Path Sites

31 last reported
1 added
1 completed Glide Path

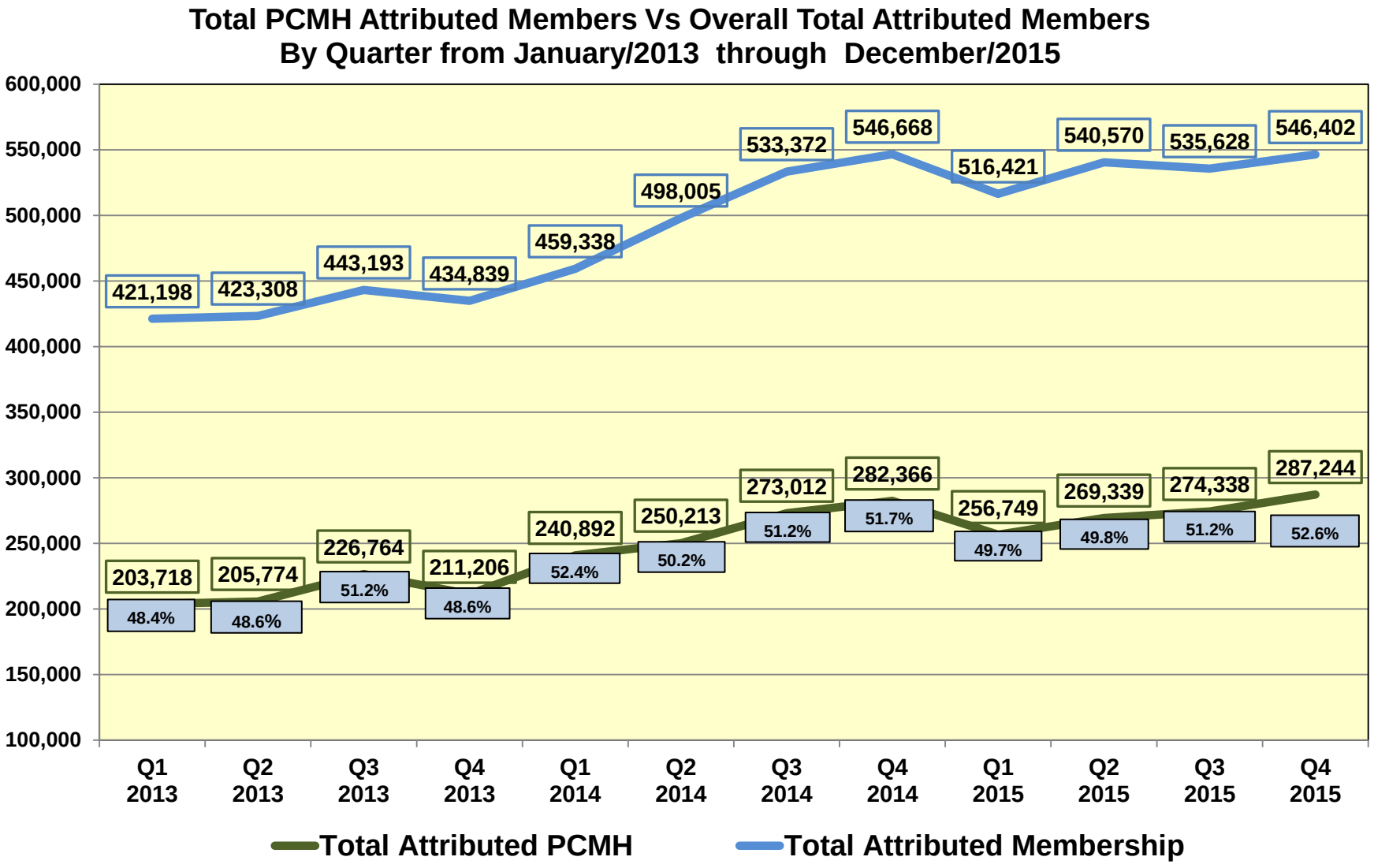
### 106 Glide Path Providers

126 last reported
2 added
22 completed Glide Path

### 1 Glide Path Renewal Practice

5 Sites
42 Providers

# PCMH Program Status Update



# PCMH Program Recruitment Update

- Recruitment 2015 Summary
  - Contacted since 1/1/2012 = 326 practices
  - Newly enrolled since 1/1/2015 = 17 practices
  - Currently enrolled = 102 practices
  - Possible recruitment opportunities = 92 practices
    - 58 open practices (“Hot” & “Actively Engaged” Prospects)
    - 34 watch-list practices (“Tentative” Prospects)
  - Open practices with EHRs = 57 practices or 98%

# Intensive Care Management
# &
# Community Support Services

***Featured Presentation***

# PCMH Program Practice Support for Care Coordination

## Health Quality Measure Target Populations:

- High ED Utilization
- High Risk Admission Reduction
- Asthma Related ED Visits
- Diabetic Related ED/Inpatient Visits
- Sickle Cell Related ED Visits
- Perinatal Related ED/Inpatient Visits
- Well Care
- Antidepressant Medication Management - Acute & Continuation Phases

## Care Coordination Team Efforts:

- Community Practice Transformation Specialists (Clinical & Non-Clinical)
- Practice Care Coordinators (Non-Clinical)
- **Intensive Care Managers (Clinical)**
- **Community Health Workers (Clinical & Non-clinical)**

# Intensive Care Management (ICM)

Community Health Network of Connecticut's ICM program focuses on care coordination to support the members' quality of life and to empower them to take control of managing their health care needs. The ICM program incorporates DSS' approach to person-centeredness, which addresses:

- Providing the member with needed information, education and support required to make fully informed decisions about his or her care options, and to actively participate in his or her self-care and care planning;

- Supporting the member and their designated representative(s) in working together with his or her medical, non-medical and behavioral health providers and care manager(s) to obtain necessary supports and services; and

- Reflecting care coordination under the direction of, and in partnership with, the member and his/her representative(s), which is consistent with his or her personal preferences, choices and strengths, and is implemented in the most integrated setting.

# ICM Goals

The ICM team provides telephonic and face-to-face interaction with members to provide care coordination and empower members to self-manage their conditions. In 2014, the ICM team focused on selected chronic conditions where hospital admission and ED utilization was high. ICM's goal was to improve care coordination and assist those individuals in managing their care with their PCP in the most appropriate setting.

In 2014, members engaged in ICM continued to show positive trends in the reduction of ED usage and hospital admissions as shown in the table below.

| Service Category | CY 2014<br><br>5,777 Members |
|---|---|
| **Utilization** | |
| **Inpatient Admissions Reduction** | -43.87% |
| **ED Utilization Reduction** | -22.72% |

# ICM Goals (cont'd)

ICM enhanced medication adherence reports to identify members with medication adherence issues who are using the ED and would benefit from ICM. The ICM team also engaged with providers, community care teams, and community agencies to promote utilization of the ICM program and participate in member specific case rounds for collaborative care planning.

Members engaged in ICM with specific conditions showed the following ED Utilization results six months post ICM engagement:

| ED Utilization | CY 2014 |
|---|---|
| **Members with Asthma** | For the 2,089 asthmatic members engaged in ICM, results showed a 22.42% reduction in their ED utilization |
| **Members with Diabetes** | For the 1,189 diabetic members engaged in ICM, results showed an 11.28% reduction in ED utilization |
| **Members with Sickle Cell Disease** | For the 85 members engaged in ICM with sickle cell disease, results showed an 18.39% reduction in ED utilization |
| **Perinatal Members** | For the 1,521 members engaged in the Perinatal ICM program, results showed a 43.42% reduction in ED utilization |

# ICM Goals (cont'd)

Members are referred or identified for ICM from various referral sources. ICM's goal is to improve member health outcomes and quality of life through the development of a member-centered care plan with a focus on preventing hospital admissions.

Members engaged in ICM with specific conditions showed the following Inpatient Admission results six months post ICM engagement:

| Inpatient Admissions | CY 2014 |
|---|---|
| Members with Asthma | For the 2,089 asthmatic members engaged in ICM, results showed a 39.79% reduction in their inpatient hospital utilization |
| Members with Diabetes | For the 1,189 diabetic members engaged in ICM, results showed a 38.40% reduction in their inpatient hospital utilization |
| Members with Sickle Cell Disease | For the 85 members engaged in ICM with sickle cell disease, results showed a 34.52% reduction in inpatient hospital utilization |
| Perinatal Members | For the 1,521 members engaged in the Perinatal ICM program, results showed a 41.00% reduction in inpatient hospital utilization |

# ICM for Members with Diabetes

Members with diabetes who have gaps in care, ED and/or inpatient utilization are targeted for engagement into CHNCT's ICM program.

In order to assess the impact the ICM program had on member health outcomes and the improved diabetic HEDIS® measure rates, CHNCT identified those members engaged in ICM in 2014 who met the criteria for inclusion in the CDC measures.

The following CDC measure is specific to the eye exam for diabetic retinal disease.

| CY 2014 | ICM Member Rate | HEDIS® Administrative Rate – Total Population |
|---|---|---|
| Comprehensive Diabetes Care – Eye Exam | **56.1%** | **50.5%** |

# ICM for Members with Asthma

Members with asthma who have gaps in care, ED and/or inpatient utilization are targeted for engagement in ICM.

ICM utilized several measures to examine improvement in the care for ICM asthmatic members engaged in 2014, which addressed:

- **ED utilization**
- **Inpatient admissions**

As discussed in the ED and Readmission sections of this evaluation, results comparing utilization six months pre-ICM engagement to six months post ICM engagement for the 2,089 Asthmatic members engaged in ICM showed:

- **ED visit utilization for ICM engaged asthmatic members decreased by 22.42%; and**
- **Admissions decreased by 39.79%**

# ICM for Perinatal Members

CHNCT's ICM program, *Healthy Beginnings*, targeted perinatal HUSKY Health members with a focus on minimizing the risk of pregnancy-related conditions.

ICM nurses engaged with pregnant members identified as high-risk due to a combination of medical, behavioral or social conditions. ICM nurses continued to identify unmet needs of high-risk members and connect members with resources, coordinate with providers to address gaps in care and link and co-manage with CTBHP for those members with behavioral health needs and other ASOs as necessary.

In 2014, CHNCT enhanced the *Healthy Beginnings* program by training ICM non-clinical support staff to proactively outreach to members and conduct risk screenings. With each of these calls, staff screened members to identify potential barriers to appointment adherence and refer members to ICM whenever appropriate.

# ICM for Perinatal Members (cont'd)

CHNCT used the CY 2014 HEDIS® Frequency of Ongoing Prenatal Care and the Prenatal and Postpartum Care measures data to identify 2014 Healthy Beginnings members within the denominator of these hybrid measures. These hybrid measures utilized a random sample size of 411.

There were 86 Healthy Beginnings members within the 411 denominator population:

| CY 2014 | Healthy Beginnings Member Rate | HEDIS® Hybrid Rate HUSKY A and B |
|---|---|---|
| Frequency of Prenatal Care >81% | **66.28%** | **62.04%** |
| Prenatal Care | **87.36%** | **85.64%** |
| Postpartum Care | **74.71%** | **70.32%** |

# ICM Member Well Care Visits

CHNCT used the following CY 2014 HEDIS® utilization measures to identify ICM members for the following:

- *Well Child Visits*, which measure the percentage of members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement year, and
- *Adolescent Well Care Visits*, which measures the percentage of members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year

The comparison of ICM members to the total population for both of these measures is as follows:

| CY 2014 | ICM Member Rate | HEDIS® Administrative Rate – Total Population |
|---|---|---|
| Well-Child Visits (Ages 3-6) | **82.3%** | **78.6%** |
| Adolescent Well Care Visits | **52.7%** | **56.6%** |

# ICM for Members with Depression

CHNCT used the CY 2014 HEDIS® Antidepressant Medication Management (AMM) measures to identify ICM members with depression for the following:

- *Effective Acute Phase Treatment*, which measures the percentage of members who remained on an antidepressant medication for at least 84 days, and
- *Effective Continuation Phase Treatment*, which measures the percentage of members who remained on an antidepressant medication for at least 180 days

The comparison of ICM members to the total population for both of these measures is as follows:

| CY 2014 | ICM Member Rate | HEDIS® Administrative Rate – Total Population |
|---|---|---|
| Effective Acute Phase Treatment | **64.8%** | **63.9%** |
| Effective Continuation Phase Treatment | **51.8%** | **48.9%** |

# Community Health Workers

- Effective Dec 1, 2015, under the purview of the ICM program, Human Service Specialist (HSS) staff are transitioning to the role of Community Health Worker (CHW)
- Desired staff experience:
  - High School diploma or GED
  - 1-3 years relevant experience with work in a community setting
  - Bi-lingual preferred
- CHW staff will begin comprehensive training in December
  - Staff attending Core Competency training conducted by Area Health Education Centers (AHEC) in Hartford
  - Additional condition specific training provided by certified asthma, diabetic and perinatal nurses at CHNCT
- Goals of the CHW are to help members and/or families:
  - Reduce barriers to accessing care
  - Learn to navigate and access community services and other resources leading to healthy behaviors
  - Empower and support members willingness to participate in health care treatment

# Community Health Workers (cont.)

- Members are referred to CHW staff by ICM Nurses via the CHW Health Risk Questionnaire (HRQ).
- Barriers to ICM services (i.e., no response to ICM outreach) are identified through the HRQ which informs specific condition needs such as:
  - Diabetic without access to routine appointments
  - Member unable to manage asthma triggers
  - First time mother
  - Unable to locate member who is high utilizer of services
- Interventions the CHW may take include:
  - Educate the member on how to access the transportation benefit
  - Review how to manage asthma triggers in the home
  - Facilitate access to WIC and infant resources (clothes, crib, etc.)
  - Try to locate member using collateral contacts, hospital visits, etc.

# Community Health Workers (cont.)

**The CHW:**

- Provides social support, community based outreach, advocacy, culturally based education, health promotion, and referrals to services for individuals and families enrolled in HUSKY Health
- Increases the member's capacity to address health and social issues and to become active participants in working toward care plan goals
- Partners with medical providers, primary care teams, and other agencies involved in improving health outcomes for members

# Community Health Workers (cont.)

**The CHW also:**

- Partners with CHNCT staff to coordinate and support the member through the healthcare continuum
- Cultivates and maintains awareness of community cultures and values
- Provides culturally and linguistically appropriate education, and referrals to community resources
- Collaborates with internal and external constituents, participates in health promotions and outreach activities in the community including community and hospital collaborative meetings

# QUESTIONS